Medicare Financing

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Summary

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A, or Hospital Insurance (HI); Part B, or Supplementary Medical Insurance (SMI); Part C, or Medicare Advantage (MA); and Part D, the outpatient prescription drug benefit. The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these are credited to the HI trust fund. The Part B program is financed through a combination of monthly premiums paid by current enrollees and general revenues. Income from these sources is credited to the SMI trust fund. Beneficiaries can choose to receive all their Medicare services, except hospice, through managed care plans under the MA program; payment is made in appropriate parts from the HI and SMI trust funds. A separate account in the SMI trust fund accounts for the Part D drug benefit; Part D is financed through general revenues, beneficiary premiums, and state contributions. The HI and SMI trust funds are overseen by a Board of Trustees that provides annual reports to Congress.

The 2014 report of the Medicare Board of Trustees estimates that the HI trust fund will become insolvent in 2030, four years later than it had predicted in the 2013 report. Because of the way that it is financed, the SMI fund cannot face insolvency; however, the Trustees project that SMI expenditures will continue to grow rapidly, and thus place increasing demands on Medicare beneficiaries and all taxpayers. Additionally, unlike in prior years, the projections in the 2014 report assume that reductions in physician payment rates scheduled under current law will not occur, because these reductions have usually been overridden by Congress. The Trustees estimate that total Medicare costs will increase from 3.5% of GDP in 2013 to 6.9% in 2088.

Although the Medicare Trustees report that the financial outlook for the Medicare program appears to have improved as a result of changes made by the Patient Protection and Affordable Care Act as amended (ACA, P.L. 111-148), they caution that the projections in the report are somewhat uncertain, due to the potential for future expenditure reductions not to materialize. As it has done each year subsequent to the enactment of ACA, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary issued a supplemental analysis that provides *illustrative alternative* projections based on the assumption that certain ACA provisions affecting Medicare provider payments will be phased out.

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Introduction

Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Generally, individuals are eligible for premium-free Part A of Medicare if they or their spouse paid Medicare payroll taxes for at least 40 quarters, are at least 65 years old, and are a citizen or permanent resident of the United States. Individuals under 65 may also qualify for coverage if they have a permanent disability, have end-stage renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (Lou Gehrig's disease).[1]

Medicare consists of four parts—A through D. Part A covers hospital services, skilled nursing facility services, home health visits, and hospice services. Part B covers a broad range of medical services, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is optional, however most beneficiaries with Part A also enroll in Part B. Part C, also known as Medicare Advantage, provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage through private plans.[2]

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and over. In 2013, the program covered 52.3 million persons (43.5 million aged and 8.8 million disabled) at a total cost of $583 billion, accounting for about 20% of national health spending and 3.5% of Gross Domestic Product (GDP). Medicare is an entitlement program, which means that it is required to pay for covered services provided to enrollees so long as specific criteria are met.

Since 1965, the Medicare program has undergone considerable change. For example, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to increase the quality and efficiency of care, and enhance certain Medicare benefits.[3] For example, under the legislation, annual updates of the prices paid by Medicare for almost all non-physician categories of health services are being reduced by the growth in economy-wide productivity (productivity adjustments). The ACA also established a new Independent Payment Advisory Board (IPAB), which is required to make recommendations to reduce Medicare spending in years in which Medicare costs are projected to exceed a target growth rate.[4] The legislation did not, however, make changes to the physician sustainable growth rate (SGR) payment system; unless Congress

[1] In addition, individuals with one or more specified lung diseases or types of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, are also deemed entitled to benefits under Part A and eligible to enroll in Part B.

[2] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[3] For additional detail, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis, and CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available to congressional clients upon request.

[4] The board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The board is prohibited from making proposals that ration care, raise taxes, increase Part B premiums, or change Medicare benefits, eligibility, or cost-sharing. As of the date of this report, the board has not yet been established. For additional information on IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

takes action before April 1, 2015, reductions in physician payment rates of about 21% will be required.[5]

Additionally, the Budget Control Act of 2011 (BCA; P.L. 112-25) provided for increases in the debt limit and established procedures designed to reduce the federal budget deficit, including the creation of a Joint Select Committee on Deficit Reduction.[6] The failure of the Joint Committee to propose deficit reduction legislation by its mandated deadline triggered automatic spending reductions ("sequestration" of mandatory spending and reductions in discretionary spending) in fiscal years 2013 through 2021. The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240) delayed the automatic reductions by two months,[7] while the Bipartisan Budget Act of 2013 (BBA, P.L. 113-67) extended sequestration for mandatory spending for an additional two years—through FY2023.[8] On February 15, 2014, the President signed into law an amended version of S. 25 (P.L. 113-82), which, among other things, included a provision to extend BCA's sequester of mandatory spending through FY2024.[9]

Section 256(d) of the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, P.L. 99-177) contains special rules for the Medicare program in the event of a sequestration. Among other things, it specifies that for Medicare, sequestration is to begin the month after the sequestration order has been issued. Therefore, as the initial sequestration order was issued March 1, 2013,[10] Medicare sequestration began April 1, 2013, and will continue through March 31, 2025. Under sequestration, Medicare's benefit structure generally remains unchanged; however, benefit related payments are subject to 2% reductions. In other words, most Medicare payments to health care providers, as well as to MA and Part D plans, are being reduced by 2%.[11] Certain Medicare payments are exempt from sequestration and therefore not reduced.[12] Some non-benefit related Medicare expenses, such as administrative and operational spending, are subject to higher reductions, 7.3% in 2014.[13]

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[5] Congress has overridden these required reductions in every year since 2003, most recently by the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) which extended the current Medicare physician fee schedule payment update of 0.5% through the rest of CY2014, and provided a 0% update for January 1, 2015, through March 31, 2015. See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

[6] For a comprehensive discussion of the BCA, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

[7] For additional information, see CRS Report R42884, *The "Fiscal Cliff" and the American Taxpayer Relief Act of 2012*, coordinated by Mindy R. Levit.

[8] Section 1205 of the Act also changed the sequestration percentages for Medicare in the last year of sequestration. Instead of reducing Medicare benefits by a uniform 2% throughout the year; the sequestration level during the first six-months is to be 2.9% and in the last 6 months, 1.1%.

[9] The Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) adjusted the Medicare sequestration reductions in FY2024 to 4% for the first 6 months and 0% for the last 6 months.

[10] See OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013 at http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

[11] See CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar, for additional detail.

[12] These exemptions include (1) Part D low-income subsidies, (2) the Part D catastrophic subsidy, and (3) Qualified Individual (QI) premiums.

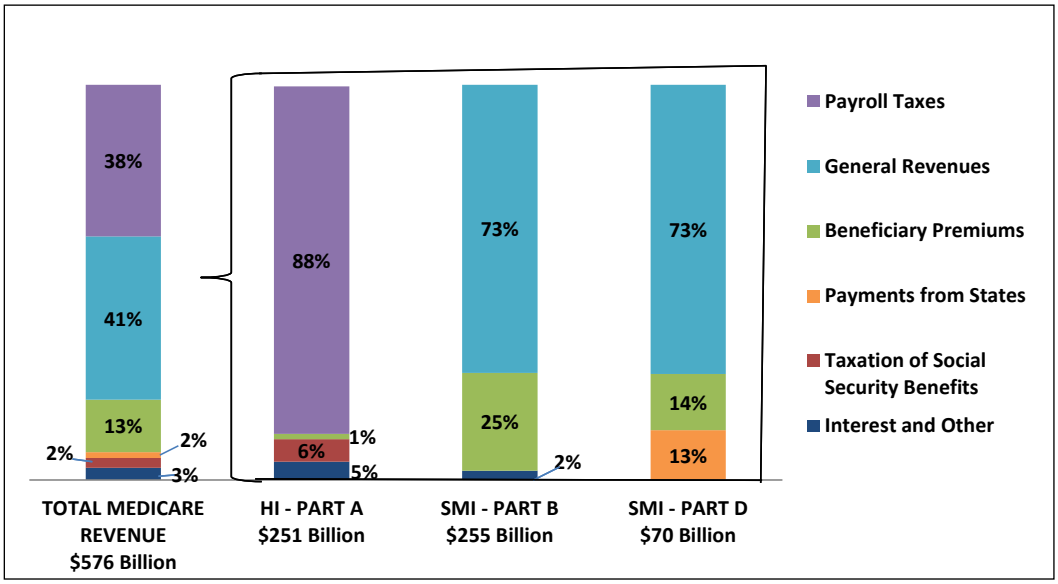
[13] See CMS accounts in OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2014 at http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy14_preview_and_joint_committee_reductions_reports_04102013.pdf.

This report provides an overview of how the Medicare program is financed, including a description of the Medicare trust funds and a summary of key findings and estimates from the 2014 Report of the Medicare Board of Trustees[14] regarding 2013 program operations and future financial soundness.[15]

Medicare Trust Funds

Medicare's financial operations are accounted for through two trust funds maintained by the Department of the Treasury—the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Parts B and D. For beneficiaries enrolled in Medicare Advantage (Part C), payments are made on their behalf in appropriate portions from the HI and SMI trust funds. HI is primarily funded by payroll taxes, while SMI is primarily funded through general revenue transfers and premiums (see **Figure 1**). The HI and SMI trust funds are overseen by a Board of Trustees that provides annual reports to Congress.

Figure 1. Sources of Medicare Revenue: 2013



Source: 2014 Report of the Medicare Trustees, Table II.B1.

Note: Totals may not add to 100% due to rounding.

Hospital Insurance (HI) Trust Fund

Covered Part A benefits, namely, inpatient hospital services, skilled nursing facility services, some home health services, and hospice care are paid for out of the HI trust fund. Payments are also made for administrative costs associated with operating this part of the program.

[14] *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf.

[15] A short summary of the financial status of the Medicare program may be found in CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis.

Similar to the Social Security system, the HI portion of Medicare was designed to be self-supporting, and is financed through dedicated sources of income rather than relying on general tax revenues. The primary source of income credited to the HI trust fund is *payroll taxes* paid by employees and employers; each pays a tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[16] ACA imposes an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers, and $250,000 for joint filers effective for taxable years beginning in 2013.[17] (ACA also imposes an additional tax on unearned income beginning in 2013; however, this tax is not credited to the trust fund.)[18]

Additional income to the HI trust fund consists of premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A through their (or their spouse's) work in covered employment; a portion of the federal income taxes paid on Social Security benefits;[19] and interest on federal securities held by the trust fund.

The HI trust fund is primarily an accounting mechanism used to track whether the program has sufficient income and assets to make payments for Part A benefits. When the government receives Medicare revenues (payroll taxes), income is credited by the Treasury to the appropriate trust fund in the form of special issue interest-bearing government securities.[20] (Interest on these securities is also credited to the trust fund.) The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A benefits are made, the payments are paid out of the general treasury, and a corresponding amount of securities is deleted from (written off) the HI trust fund.

The trust fund surpluses are not reserved for future Medicare benefits, but are simply bookkeeping entries that indicate how much Medicare has lent to the Treasury (or alternatively, what is owed to Medicare by the Treasury). From the unified budget perspective, these "asset" balances are regarded as future spending obligations and are thus treated as liabilities.[21] (See the "Medicare Expenditures and the Federal Budget" section for an overview of differences in trust fund and unified budget accounting conventions.)

As long as the HI trust fund has a balance, the Treasury Department is authorized to make payments for Medicare Part A services. To date, the HI trust fund has never run out of money (i.e., become *insolvent*), and there are no provisions in the Social Security Act that govern what

[16] Prior to 1991, the upper limit on taxable earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) raised the limit in 1991 to $125,000. Under automatic indexing provisions, the maximum was increased to $130,200 in 1992 and $135,000 in 1993. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) eliminated the upper limit entirely beginning in 1994.

[17] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, for additional detail.

[18] For more information on this tax, see CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark P. Keightley; and the *2014 Medicare Trustees Report*, page 22, footnote number 14.

[19] Since 1994, the HI fund has had an additional funding source. OBRA 93 increased the maximum amount of Social Security benefits subject to income tax from 50% to 85% and provided that the additional revenues would be credited to the HI trust fund.

[20] Unlike marketable securities, special issues can be redeemed at any time at face value. Investment in special issues gives the trust funds the same flexibility as holding cash.

[21] The Congressional Budget Office argues that trust fund balances are not meaningful from an economic standpoint, rather they primarily serve a bookkeeping role. See Congressional Budget Office, *Federal Debt and Interest Costs*, December 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/119xx/doc11999/12-14-federaldebt.pdf.

would happen if that were to occur. For example, there is no authority in law for the program to use general revenue to fund Part A services in the event of such a shortfall. Since the beginning of the Medicare program, the payroll tax rate has been adjusted periodically by Congress as one of the mechanisms to maintain the financial adequacy of the HI trust fund.[22] Additionally, Congress has taken numerous actions to slow the growth in expected Part A spending.[23]

Supplementary Medical Insurance (SMI) Trust Fund

Medicare Part B benefits (which include physician services, outpatient hospital care, some home health services, durable medical equipment, diagnostic tests, and other services) and Part D outpatient prescription drug benefits are paid for out of the Supplementary Medical Insurance (SMI) trust fund.[24] Unlike the HI program, the SMI program was not intended to be fully supported through dedicated sources of income. Instead, it relies primarily on general tax revenues and beneficiary premiums as revenue sources.

Because contributions (general revenue and premiums) into the SMI trust fund are automatically updated each year to ensure that the program has enough money to continue operating, the SMI trust fund is kept in balance and will remain in financial balance indefinitely (i.e., the SMI trust fund cannot become insolvent). Income from these sources is credited to the SMI trust fund and any SMI revenues that exceed SMI spending accumulate in the SMI trust fund; however, SMI trust fund balances are generally small. Similar to HI, the basic structure of the SMI financing system can be changed only through an act of Congress.

Part B Financing

Medicare Part B is financed mostly by federal general revenues, and beneficiary premiums are set at a rate to cover 25% of estimated Part B program costs for the aged.[25] Beginning in 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs (including biological products and excluding orphan drugs) are being credited to the Part B account in the SMI trust fund.[26]

In 2014, the monthly premium is $104.90 for most Medicare Part B enrollees, and individuals who receive Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks.[27] Since 2007, high-income enrollees pay higher premiums.[28] As a result of a provision in ACA, the income thresholds used to determine which

[22] Historical Medicare payroll tax rates may be found in Appendix B of CRS Report RS20946, *Medicare: Insolvency Projections*, by Patricia A. Davis.

[23] Specific actions that have been taken are outlined in CRS Report RS20946, *Medicare: Insolvency Projections*.

[24] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), which created the Part D outpatient prescription drug benefit, added the Part D account to the SMI trust fund. The Part D program began operation in 2006.

[25] See CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[26] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, for more detail.

[27] Due to a "hold harmless" provision in the Social Security Act, (Section 1839(f)) an individual's Social Security check cannot go down from one year to the next as a result of the annual Part B premium increase. High-income individuals, new enrollees, those eligible for both Medicare and Medicaid (dual-eligibles), and those who do not have premiums deducted from their Social Security checks are not covered by this provision.

[28] The higher monthly premium amounts for 2014 are based on 2012 income levels and are (1) $146.90—for single beneficiaries with annual incomes of $85,000.01-$107,000 or for each member of a couple filing jointly with incomes of $170,000.01-$214,000; (2) $209.80—for single beneficiaries with incomes of $107,000.01-$160,000 or for each

beneficiaries are subject to higher Part B premium rates will be frozen at 2010 levels through 2019. Over time, this freeze will result in a larger number of beneficiaries paying the higher premiums and is expected to bring in increased revenue to the SMI trust fund.

Part D Financing

Medicare Part D is primarily financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. These transfers, referred to as "clawback payments," represent a portion of the amounts states could otherwise have been expected to pay for drugs under Medicaid if drug coverage for the dual-eligible population (those who qualify for both Medicare and Medicaid) had not been transferred to Part D.[29]

In 2014, the base monthly premium is $32.42; however, beneficiaries pay different premiums depending on the Part D plan they have selected (and whether they are entitled to low-income premium subsidies). Part D premium payments may be automatically deducted from Social Security benefit checks, paid directly to the prescription drug plan sponsor, or made through an electronic funds transfer.[30] Premiums for the Part D program are required to cover 25.5% of standard benefit costs; however, as recipients of the Part D low-income subsidies are not required to pay premiums, premiums covered only about 14% of Part D program costs in 2013 (see **Figure 1**). As required by ACA, beginning in 2011, high-income Part D prescription drug program enrollees are required to pay higher premiums similar to high-income Part B enrollees; the income thresholds are set at the same levels as those under Part B and frozen in the same manner through 2019.

Board of Trustees

The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the HI and SMI trust funds. By law, the six-member Board is composed of the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, the Commissioner of Social Security, and two public members (not of the same political party) nominated by the President and confirmed by the Senate.[31] The Secretary of the Treasury is the Managing Trustee, and the Administrator of the Centers for Medicare & Medicaid Services (CMS) is designated the Secretary of the Board.

Annual Trustees Report

The Medicare Trustees provide a report to Congress each year on the operations of the trust funds. Financial projections included in the report are made by CMS actuaries using major economic and other assumptions selected by the Trustees based on current law. Among the

member of a couple filing jointly with incomes of $214,000.01-$320,000; (3) $272.70—for single beneficiaries with incomes of $160,000.01-$214,000 and each member of a couple filing jointly with incomes of $320,000.01-$428,000; and (4) $335.70—for single beneficiaries with incomes greater than $214,000 and each member of a couple filing jointly incomes above $428,000.

[29] Prior to the start of the Medicare prescription drug benefit in 2006, dual-eligible enrollees primarily received their drug coverage through Medicaid.

[30] The "hold harmless" provision described in the footnote on the previous page does not apply to Part D; beneficiaries are not protected from Part D premium increases.

[31] Charles P. Blahous III and Robert D. Reischauer were confirmed by the Senate on September 16, 2010 to be the public members of the Medicare and Social Security Boards of Trustees.

variables used are estimations of consumer price index (CPI), fertility rate, mortality rate, workforce size, wage increases, and life expectancy. The Trustees review these assumptions annually, and update them as warranted by new analyses of trends and data.[32] The report includes three forecasts ranging from pessimistic ("high cost") to mid-range ("intermediate") to optimistic ("low cost"). The intermediate projections represent the Trustees' best estimate of economic and demographic trends and are the projections most frequently cited. (Unless otherwise noted, the intermediate projections are used throughout this report.)

The 2014 report of the Medicare Trustees was issued July 28, 2014.[33] As noted, the Medicare Trustees generally make their projections based on current law. However, in their 2014 report, the Trustees made an exception with regard to the sustainable growth rate (SGR) formula for physician payments under Part B. Although under current law, physician payments are scheduled to be reduced by close to 21% in April 2015, the Trustees recognized that in every year since 2002, Congress has overridden these reductions.[34] The Trustees therefore used a "projected baseline" that assumed that physician payments would remain at their current levels through the end of 2015, and then increased by 0.6% annually through 2023.[35]

However, even with the above change in projection methodology, the report warned that estimates based on other current-law assumptions may not be realistic. As such, the actuaries of CMS conducted a separate analysis that provides projections based on an "illustrative alternative" to current law.[36] The alternative estimates are based on the assumption that the economy-wide productivity adjustments mandated by ACA would be made through 2019, but would then be phased out from 2020 to 2034, and that IPAB recommendations for cost reductions would not be implemented.

2013 Medicare Program Operations

In calendar year (CY) 2013, Medicare provided about 52.3 million beneficiaries with benefits at a total cost of about $583 billion, or an average of $11,910 per enrollee. (See **Appendix A**, **Appendix B**, and **Appendix C** for historical and projected enrollment, total Medicare income and

[32] Additionally, their projection methodology is reviewed periodically by an independent panel of expert actuaries and economists who make recommendations to the Board regarding the most appropriate long-range growth assumptions for Medicare projections. Most recently, the Board of Trustees convened an independent panel in 2010, and the panel issued its final report in 2012, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections*, Technical Review Panel on the Medicare Trustees Reports, December 2012, http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

[33] The 2014 report includes data on actual expenditures and income through 2013, and projections for years 2014 and beyond. *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf .

[34] See CRS Report R43430, *The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions*, by Jim Hahn.

[35] This is equal to the average of the SGR overrides over the most recent 10 years. See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

[36] *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Appendix C: Current Law and Illustrative Alternative Projections; and memo from John D. Shatto and M. Kent Clemens, CMS Office of the Actuary, "Projected Medicare Expenditures under Current Law, the Projected Baseline, and an Illustrative Alternative Scenario," Aug. 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf.

expenditures, and per capita expenditures.) Because HI and SMI have different funding mechanisms, a description of each fund's 2013 operations is presented separately below.

Hospital Insurance Trust Fund Operations in 2013

As shown in **Table 1**, in CY2013, total income to the HI trust fund was $251.1 billion. Payroll taxes of workers and their employers accounted for $220.8 billion (87.9%), with the remainder coming from interest and government credits, premiums (from those buying into the program), and taxation of Social Security benefits. The HI program paid out $266.2 billion, most of which was for benefit costs; the rest, about 1.6%, was used for administrative expenses. Similar to years 2008 through 2012, expenditures again exceeded income in 2013, and the trust fund balance was reduced from $220.4 billion at the end of 2012 to $205.4 billion at the end of 2013 (a loss of $15.0 billion).[37] (See **Appendix D** for funding amounts in prior years and estimates for future years.)

Table 1. Medicare Data for Calendar Year 2013

	HI - Part A	SMI - Part B	SMI - Part D	Total Medicare
Enrollment (millions)				
Aged	43.1	40.0	n/a	43.5
Disabled	8.8	7.9	n/a	8.8
Total	51.9	47.9	39.1	52.3
Average expenditures per enrollee	$5,045	$5,092	$1,773	$11,910
Trust Fund Balance at end of 2012 (billions)	**$220.4**	**$66.2**	**$1.0**	**$287.6**
Total Income	**$251.1**	**$255.0**	**$69.7**	**$575.8**
Payroll Taxes	220.8	—	—	220.8
Interest	9.3	2.4	0.0	11.7
Taxation of Benefits	14.3	—	—	14.3
Premiums	3.4	63.1	9.9	76.4
General Revenue	0.9	185.8	51.0	237.7
Transfers from States	—	—	8.8	8.8
Other	2.4	3.7	—	6.1
Total Expenditures	**$266.2**	**$247.1**	**$69.7**	**$582.9**
Benefits	$261.9	$243.8	$69.3	$575.0
Hospital	136.8	41.8	—	178.6
Skilled Nursing	28.4	—	—	28.4

[37] In comparison, in CY2012, total HI income was $243.0 billion and total disbursements were $266.8 billion. The CY2013 estimates represent an increase in income of $8.1 billion (a 3.3% increase) and a reduction in expenditures of $0.6 billion (a 0.2% decrease) from 2012 to 2013.

	HI - Part A	SMI - Part B	SMI - Part D	Total Medicare
Home Health Care	6.8	11.5	—	18.4
Physician Services	—	68.6	—	68.6
Private plans (Part C)	73.2	72.7	—	145.9
Prescription Drugs	—	—	69.3	69.3
Other	16.7	49.2	—	65.8
Administrative Expenses	$4.3	$3.3	$0.4	$7.9
Net Change	-$15.0	$7.9	$0.0	-$7.1
Trust Fund Balance at end of 2013	**$205.4**	**$74.1**	**$1.0**	**$280.5**

Source: 2014 Report of Medicare Trustees, Table II.B1.

Notes: Totals do not necessarily equal the sums of rounded components; n/a = data not available.

Supplementary Medical Insurance Trust Fund Operations in 2013

In CY2013, the SMI trust fund (Part B and Part D accounts combined) brought in $324.7 billion in revenue ($255.0 billion from Part B and $69.7 billion from Part D), and expended $316.8 billion ($247.1 billion from Part B and $69.7 from Part D); the $7.9 billion surplus was added to the SMI trust fund balance. General revenues accounted for 72.9% of total income, and premiums accounted for 22.5%.[38] (See **Table 1** for 2013 Parts B and D operations data.)

Of the $255.0 billion in income to Part B, general revenues made up $185.8 billion of that amount (72.9%), premiums accounted for $63.1 billion (24.7%), and interest and other income made up the remaining $6.1 billion (2.4%). In 2013, the program paid out $247.1 billion; similar to HI, almost all of this amount was used to cover benefits, while the remaining 1.3% covered administrative expenses.[39] (See **Appendix E** for historical and projected income and expenditures in the SMI Part B account.)

Of the $69.7 billion in Part D income, general revenues accounted for $51.0 billion (73.2%), premiums accounted for $9.9 billion (14.2%), and transfers from states for $8.8 billion (12.6%). Almost all of the 2013 Part D program expenditures of $69.7 billion were used to pay benefit costs, and the rest, about 0.6%, was used for administrative expenses.[40] (See **Appendix F** for historical and projected income and expenditures in the SMI Part D account.)

Short-Range Financial Soundness (10 Years)

Over the next 10 years, total Medicare expenditures are projected to increase at an average annual rate of 6.8%,[41] with total spending growing from $582.9 billion in 2013 to close to $1.1 trillion in 2023 (see **Figure 2** and **Appendix B**). The average growth rate reflects the expected growth in the number of individuals eligible for Medicare as well as expected increases in utilization and

[38] In comparison, in CY2012, total income for SMI was $293.9 billion and total expenditures were $307.4 billion. This represents a growth in SMI expenditures of $9.4 billion, or an increase of 3.1%, from 2012 to 2013.

[39] This represents an expenditure increase of 2.7% over the $240.5 billion in Part B expenditures in 2012.

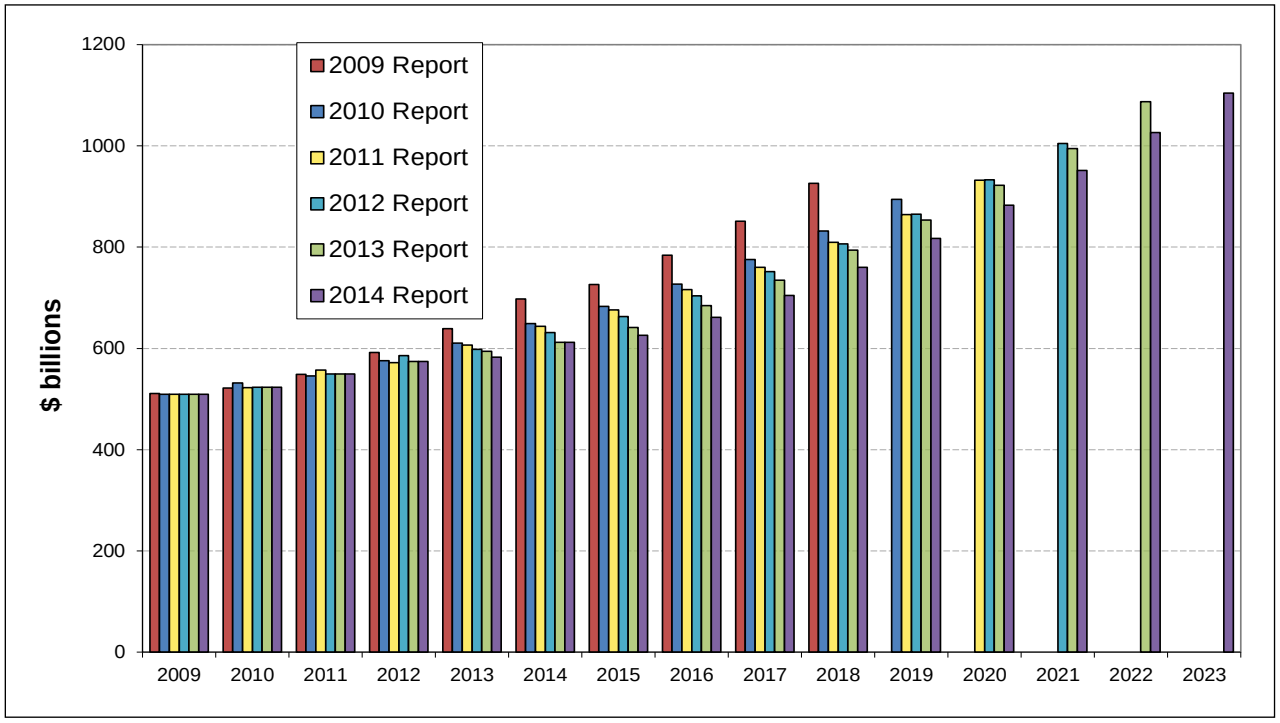
[40] The 2013 Part D expenditures represent a 4.2% increase over the 2012 expenditures of $66.9 billion.

[41] By comparison, total Medicare expenditures grew at an average annual rate of 7.7% from 1985 to 2013.

complexity of services per beneficiary and in the prices of those services. The growth rate also factors in ACA changes that affect cost growth rates, such as the productivity adjustments to the annual payment updates to certain providers and changes in payments to Medicare Advantage plans. Additionally, unlike in prior years' projections, these growth rates assume that the scheduled physician payment reductions of about 21% in April 2015 will not go into effect.

Figure 2. Total Medicare Expenditures

Comparison of Estimates of 2009-2014 Medicare Trustees Reports



Sources: Data from the 2009, 2010, 2011, 2012, 2013, and 2014 Reports of the Medicare Boards of Trustees, Table III.A1 (2009-2011) and Table V.B1 (2012-2014).

Notes: The 2009 report was issued prior to ACA enactment. Reports issued in 2010 and beyond incorporate ACA changes into projections of estimated spending. The 10-year projection window for the 2009 report only extended to 2018; there are no corresponding projections for 2019 through 2022. Similarly, the 2010 through 2013 report projections only extend to 2019 through 2022, respectively.

HI Short-Range Financial Status

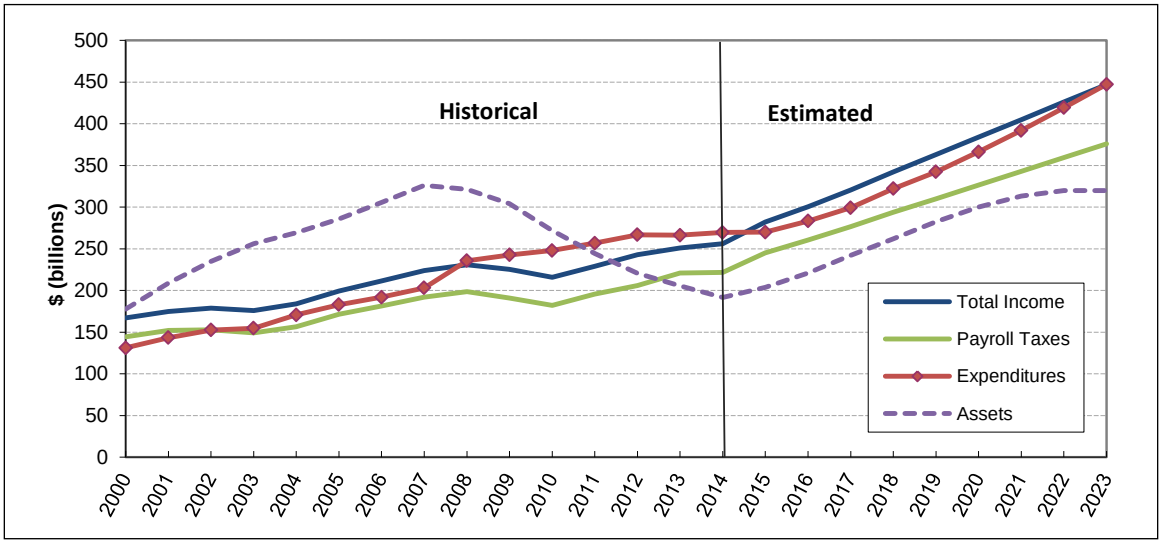
In the short term, the adequacy of the HI trust fund is determined by comparing its assets at the beginning of the year to expected costs for that year. The Trustees consider the fund to be adequate if the ratio of assets to expenditures is at least 100% at the beginning of and throughout the 10-year projection period.[42] The Trustees note that the HI fund is not adequately financed over the next 10 years. Specifically, the new report states that the fund fails to meet the short-range (i.e., 10-year, 2014-2023) test of financial adequacy because total HI assets at the start of the year ($205.4 billion) are expected to be below 100% of expenditures (76%) during 2014.

[42] If the ratio is less than 100% at the beginning of the 10-year period, it must increase to 100% within 5 years and then remain at or above 100% during the rest of the period. This amount is considered a sufficient contingency reserve to allow Congress enough time to address any anticipated short-term financing problems.

HI expenditures have exceeded income every year since 2008 and are projected to continue doing so under current law through 2014. In 2009 and 2010, income from payroll taxes decreased substantially due to higher unemployment and slow growth in wages. In years 2011 through 2013, revenues grew faster than expenditures; however, they still did not reach the level of expenditures in those years, as spending also continued to increase due to growing Medicare enrollment and periodic updates to Medicare provider payment rates.

Income is expected to continue increasing at a faster rate than expenditures from 2014 through 2017 due to the assumed continuation of the economic recovery, the application of an additional 0.9% HI payroll tax for high-income enrollees beginning in 2013, and the 2% reduction in benefit spending required by BCA from April 1, 2013, through March 31, 2024. Over the next 10 years, HI income is expected to grow on average by 5.9% per year, while expenditures are expected to grow at an average rate of 5.3% per year. From 2015 through 2022, the HI trust fund is expected to run a slight surplus; after that period, expenditures are once again expected to outpace income. (See **Figure 3**.)

Figure 3. Short-Term HI Expenditures and Income



Source: Data from 2014 Report of Medicare Trustees, Table III.B4.

Note: The Trustees report does not project dollar figures beyond 2023.

SMI Short-Range Financial Status

As premium and general revenue income for Medicare Parts B and D are reset each year to match expected costs, the SMI trust fund is deemed to be adequately financed over the next 10 years and beyond. However, over the past five years, Medicare Part B costs have been growing rapidly—by an average of 6.2% annually, exceeding GDP average growth by 3.5 percentage points. If, as assumed by the Trustees, Congress overrides physician payment reductions as it has done in the past, the Part B growth rate during this period is projected to average about 5.7% each year over the next five years. However, should the physician payment cuts be allowed to go into effect beginning in April 2015 as required under current law, Part B expenditures (and corresponding income) are expected to grow at a slower average growth rate of 4.9% annually over the next five years (2014-2018), slightly lower than expected GDP growth over the same period (5.0%).

For Part D, annual average growth over the past five years has been around 7.2%; however, due to expected growth in per person drug costs (in part due to increased costs associated with

phasing out the Part D coverage gap)[43] and expected growth in the number of enrollees, the average annual increase in expenditures is estimated to be 9.9% through 2018.[44] However, over the next 10 years, estimated Part D costs are somewhat lower than projected in the prior Trustees report due to lower expected drug costs and higher expected rebates from drug manufacturers.[45]

Projected Date of HI Insolvency

Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund.[46] As noted in the section "Medicare Trust Funds," in years in which HI expenditures exceed income, the program still has authority to continue to make payments as long as the trust fund has a balance. However, when the trust fund balance reaches $0, it is deemed insolvent and this part of the program would no longer have the authority to cover expenditures that exceed HI trust fund income. The 2014 Trustees report estimates that the HI trust fund will become insolvent in 2030, four years later than projected in last year's report (see **Figure 4**). The improved projections are primarily due to lower than expected expenditures in 2013, the base year used to project future expenditures, and reductions in assumptions of utilization of Part A services.

In the past decade, beginning in 2004, HI expenditures began exceeding *tax* income (from payroll taxes and from the taxation of Social Security benefits). Expenditures began to exceed *total* income (tax income plus all other sources of revenue) in 2008. (Refer to **Figure 3** for illustration of expenditure and income trends through 2023.) At that time, HI assets (the balance of the HI trust fund at the beginning of the year) were used to meet the portion of expenditures that exceeded income (the *HI deficit*). Expenditures have exceeded income every year since then, and are expected to continue doing so through 2014. Although the trust fund is projected to run a small surplus in years 2015 through 2022, after that time expenditures are expected to again exceed income, with trust fund assets making up the difference until the asset balance is depleted in 2030. At that time, the trust fund is projected to only have sufficient income to cover 85% of Part A expenditures. Unless action is taken prior to that date to increase HI revenue and/or decrease expenditures, Congress would need to appropriate additional funding (e.g., through general revenue transfers) to make up for these deficits and to allow for full and on time payments to providers of Part A services.

[43] After the beneficiary and the prescription drug plan together have spent a certain amount of money for covered drugs during a year, there is a gap in Part D coverage. During the coverage gap (also known as the "doughnut hole"), the beneficiary pays a large portion of his or her prescription drug expenditures. Once a certain threshold is reached, Medicare again begins providing substantial coverage. The ACA gradually reduces the amount of beneficiary cost-sharing during this gap each year from 2011 to 2020.

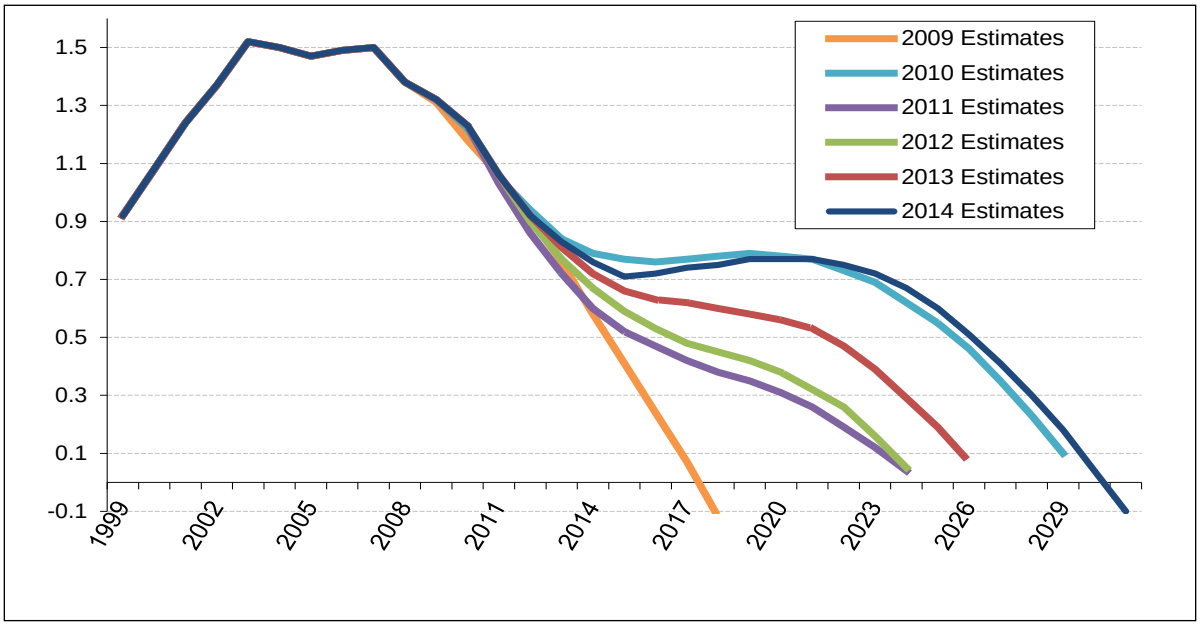
[44] The average annual growth per enrollee is expected to be 5.3% over the next five years.

[45] Medicare Part D prescription drug plans often negotiate with drug manufacturers to reduce their drug prices, and manufacturers may agree to provide rebates which are calculated as a percentage of the price of a drug. The Trustees project that the average amount of these rebates will increase from 12% in 2013 to 13.4% in 2023.

[46] For a history of projections of insolvency dates, see CRS Report RS20946, *Medicare: Insolvency Projections*, by Patricia A. Davis.

Figure 4. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures

Comparison of Estimates from 2009-2014 Trustees Reports



Sources: Data from the 2009 Medicare Trustees Report, Table II.E1, and Summaries of the 2010, 2011, 2012, and 2013 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D (2010 and 2011) and Chart E (2012, 2013 and 2014).

Note: For the 2014 estimate, percentages through 2013 are actual and those beyond 2014 are projections.

Because the impact of the ACA productivity adjustments on projected HI expenditures is relatively modest in the short term, the expected trust fund exhaustion date provided in the *illustrative alternative,* 2029, is only a year earlier than that under the projected baseline scenario.

Long-Range Financial Soundness (75 Years)

For projections beyond 2023, the Medicare Trustees do not provide actual dollar figures due to the difficulty of making meaningful comparisons of dollar values for different time periods over a long timeframe. Instead, the long-term financial soundness of the Medicare program is generally determined using one or more of the following measures:

- A comparison of the program's income and its cost as a percentage of taxable payroll (how much would need to be added to the payroll tax to keep HI solvent—this measure is only applicable to the HI trust fund);
- A determination of the present value of the program's unfunded liabilities over a particular period (the amount in today's dollars that would be needed to be in the trust fund for the program to remain financially sound for a specified period); and/or
- A comparison of expected benefit costs with GDP, the most frequently used measure of the total output of the U.S. economy (the amount spent on Medicare compared to the size of the economy in general).

The Trustees caution that while these estimates can provide indications as to whether the trust funds are in adequate financial condition, financial outcomes are inherently uncertain, especially over a very long time period.

HI Income and Costs Relative to Payroll Taxes

The long-range financial soundness of the HI trust fund is often determined by comparing the fund's *income rate* (the ratio of tax income, including payroll taxes and taxes on Social Security benefits, to taxable payroll) with its *cost rate* (the ratio of program expenditures to taxable payroll). The term *taxable payroll* refers to the total amount of wages, salaries, and self-employment income in the economy that is subject to the HI tax. By relating income and expenditure projections to expected future taxable payroll, comparisons can be made for long periods of time without the distortions caused by the changing value of the dollar (e.g., through inflation). Additionally, it indicates the relative amount of the nation's earnings that may be needed to cover the program's commitments in the future when compared to what is needed today.

Year-by-Year Estimates

In the past, *cost rates* have generally increased over time, rising from 0.94% in 1967 to 3.39% in 1996 (see **Figure 5**). This growth reflects both the higher rate of increase in medical care costs than in average earnings subject to HI taxes and the higher rate of increase in the number of HI beneficiaries than in the number of covered workers. Cost rates after that time have fluctuated primarily due to the passage of legislation affecting Medicare expenditures, including the Balanced Budget Act of 1997 (P.L. 105-33) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), as well as favorable economic performance. From 2008 through 2011, cost rates increased each year (3.30%, 3.67%, 3.69%, and 3.68%, respectively)[47] due to the lower amount of taxable payroll resulting from the recession and subsequent slow recovery. Due to slower growth in Medicare spending, the 2012 cost rates decreased to 3.60%, and decreased again in 2013 to 3.55%. The 2014 Trustees report projects that in the short term, as a result of the expected continued economic recovery and changes made by the ACA, the cost rate will continue to decline through 2017. Over the long run, however, expenditures as a percentage of taxable payroll are expected to increase to 5.57% by 2085, primarily due to the aging of the baby boom generation and expected growth in health care costs. Under the *illustrative alternative*, the expected HI cost rate for 2085 is 8.75%.

The HI *income rate* is projected to increase gradually from 3.28% in 2013 to 4.26% in 2085 primarily due to ACA's 0.9% increase in payroll taxes for high-income earners starting in 2013. As the income thresholds used to determine who qualifies as "high-income" are not indexed to grow with inflation, it is expected that more workers will be subject to this higher tax rate over time.[48] Additionally, it is expected that income from taxation of Social Security benefits will increase as the number of Social Security recipients increases over time. Because the *illustrative alternative* only assumes changes in payments, the income rate is the same as that in the baseline projection of the 2014 Trustees report.

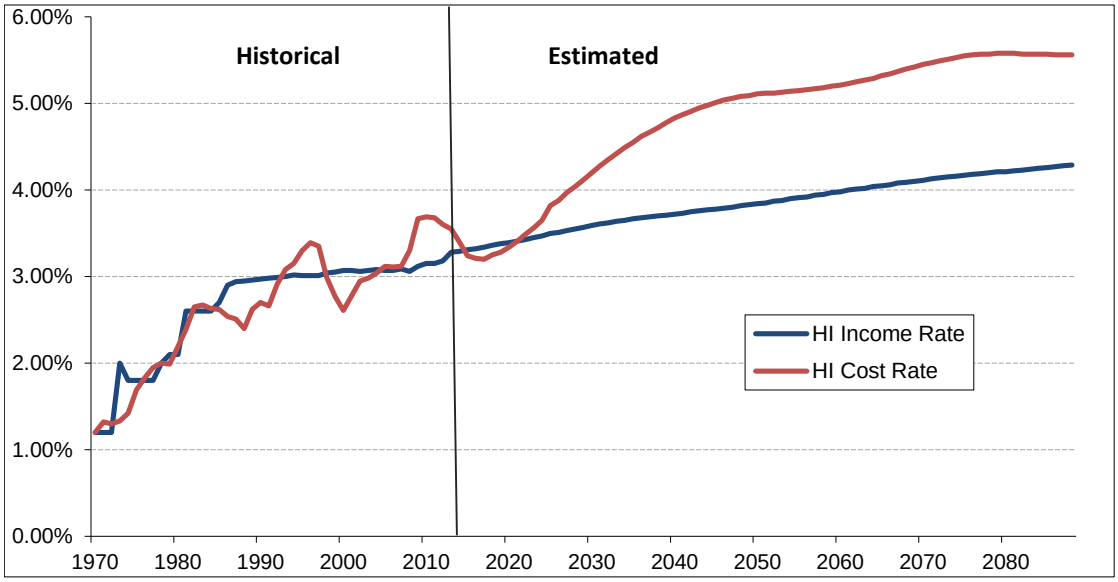
As indicated earlier, HI expenditures in most future years are expected to exceed income, resulting in a negative difference between cost and income rates. In 2030, non-interest income is

[47] *Report of the Medicare Trustees*, Table III.B7-HI Cost and Income Rates, p. 64.

[48] The Trustees project that by the end of the long-range projection period, approximately 80% of workers will be paying the higher tax rate.

expected to cover 85% of HI expenditures, decline to 75% by 2045 and stay about the same level for the remainder of the 75-year projection period. The slowing of the growth of the cost rate beyond 2045 is due to the expected compounding of the ACA reductions in provider payment updates and the assumed slowing of growth in the volume and intensity of services used by Medicare beneficiaries.

Figure 5. Long-Range HI Income and Cost as a Percentage of Taxable Payroll



Source: Data from Summary of the 2014 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart B, http://www.ssa.gov/oact/TRSUM/images/LD_ChartB.html.

Note: Rates through 2013 are actual; rates for 2014 and beyond are projections.

The 2014 Trustees report estimates that at the end of the 75-year period, there will be an HI deficit (difference between the cost rate and the income rate) of 1.31% of taxable payroll.[49] Under the *illustrative alternative* scenario, which assumes that the ACA productivity adjustments will eventually be phased out, the HI deficit at the end of the 75-year period is expected to be about 4.64% of taxable payroll.

Actuarial Balance

The *actuarial balance* can be interpreted as the percentage that would need to be added to the current-law income rates and/or subtracted from the current-law cost rates in each of the next 75 years in order for the financing to support HI costs and to meet the targeted trust fund balance at the end of the projection period. The actuarial balance of the HI trust fund is defined as the difference between the sum of the *income rate* expected for each year in the 75-year projection period (including the beginning trust fund balance) and the sum of the *cost rates* for each year, expressed as a percentage of taxable income. This summarized rate is based on the present values of future income, costs, and taxable payroll.[50]

The 2014 Trustees report estimates that the summarized HI *income rate* for the entire 75-year period is 3.82% of taxable payroll and the summarized *cost rate* is expected to be 4.69%. The difference, the *actuarial balance*, is -0.87%. Because this is a negative number, the HI trust fund

[49] The projected deficit is lower than the deficit of 1.59% in the prior Trustee's report.

[50] Present value is the current worth of a future sum of money or stream of cash flows given a specified rate of return.

fails to meet the Trustees' long-range test of actuarial balance. This means that the income rate would need to increase by 0.87% of taxable payroll throughout the next 75 years for the trust fund to reach actuarial balance (e.g., by increasing the standard payroll tax from 2.90% to 3.77%), program spending would need to be reduced by a corresponding amount, or some combination of the two would need to occur. (The Trustees note that if no changes in the payroll tax or HI spending occur prior to 2030, then the required increase after that time would be 1.21% of taxable payroll.) If the productivity adjustments to HI provider payment updates cannot be continued in the long run, the CMS actuaries estimate that the actuarial deficit would be much higher, 1.92% of taxable payroll, under their *illustrative alternative* scenario.

Unfunded Obligations

The *unfunded obligation* is a measure of the long-term funding shortfall of the Medicare program. It is defined as the difference between the present value of the expected cost of the Medicare program over a specified time period and the present value of projected income (including the initial value of the trust fund). Put another way, the unfunded obligation is the amount of money that would have to be added to the trust funds today to make the program financially sound over a specified time period.

HI Long-Term Obligations

The 2014 Trustees report estimates that the unfunded obligation of the HI trust fund is $3.6 trillion (0.4% of the present value of GDP) over the next 75 years. This means that if $3.6 trillion were added to (or expenditures reduced from) the trust fund at the beginning of 2014, the program could meet the projected cost of current-law expenditures over the next 75 years.

The Trustees note that limiting the estimates of HI unfunded obligations to 75 years understates the full magnitude of these obligations because the 75-year measures only reflect the full amount of taxes paid by the next few generations of workers, but not the full amount of their expected benefits. Therefore, since 2004, the Trustees report has included a measure of unfunded obligations that extends indefinitely (through infinity). Such extended projections can help indicate whether the HI financial imbalance would be improving or continuing to worsen beyond the 75-year period. In making these estimates, the Trustees assume that the current-law HI program, demographic, and economic trends used for the 75-year projection will continue indefinitely, except that average HI expenditures per beneficiary will increase at the same rate as GDP per capita less the productivity adjustments beginning in 2088. If the slower ACA price updates were to continue indefinitely, then the HI financial imbalance actually improves beyond the 75-year period. Under these assumptions, over the infinite horizon, the HI program is projected to have a deficit of $1.9 trillion, 0.1% of GDP (see **Table 2**).

Table 2. Unfunded HI Obligations

(Present values as of January 1, 2014)

	Present Value	% of GDP
Unfunded obligations through 2088	$3.6 trillion	0.4%
Unfunded obligations through infinite horizon	$1.9 trillion	0.1%

Source: 2014 Medicare Trustees Report, Table V.G1.

SMI Long-Term Obligations

Due to its automatic financing provisions, the SMI account is expected to be adequately financed into the indefinite future; therefore the unfunded obligations are considered to be $0 (see **Table 3**). However, estimated SMI expenditures of $33.6 trillion over the next 75 years are expected to exceed premium revenues and state payments by $24.7 trillion; general fund transfers of this amount will be needed to keep the SMI trust fund in balance for the next 75 years.[51]

Table 3. Unfunded Part B and Part D Obligations

(Present values as of January 1, 2014; dollar amounts in trillions)

	SMI—Part B		SMI—Part D	
	Present Value	**% of GDP**	**Present Value**	**% of GDP**
Unfunded obligations through 2088	$0.0	0.0%	$0.0	0.0%
Expenditures through 2088	$24.3	2.5%	$9.3	0.9%
Revenues through 2088				
General Revenue Contributions	17.9	1.8	6.8	0.7
Beneficiary Premiums	6.4	0.6	1.6	0.2
State Transfers	—	—	0.9	0.1
Fees related to brand-name drugs	0.1	0.0	—	—
Unfunded obligations through infinite horizon	$0.0	0.0%	$0.0	0.0%
Expenditures through infinite horizon	$43.0	2.6%	$19.4	1.2%
Revenues through infinite horizon				
General Revenue Contributions	31.5	1.9	14.2	0.9
Beneficiary Premiums	11.4	0.7	3.4	0.2
State Transfers	—	—	1.8	0.1
Fees Related to brand-name drugs	0.1	0.0	—	—

Source: 2014 Medicare Trustees Report, Tables V.G3 and V.G5.

Note: Totals may not add due to rounding.

The estimated present value of Part B expenditures through the infinite horizon is $43.0 trillion, of which $24.3 trillion would occur during the first 75 years. Approximately 26% of expenditures for each time period would be financed through beneficiary premiums, and a fraction of a percent would be financed through fees collected related to brand-name prescription drugs. The remaining 74% is expected to be paid by general revenues. Similarly, the estimated present value of Part D expenditures through the infinite horizon is $19.4 trillion, of which $9.3 trillion would occur during the first 75 years. For each time period, approximately 17% of expenditures would be financed through beneficiary premiums, 10% through state transfers, and the remaining 73% funded by general revenues.

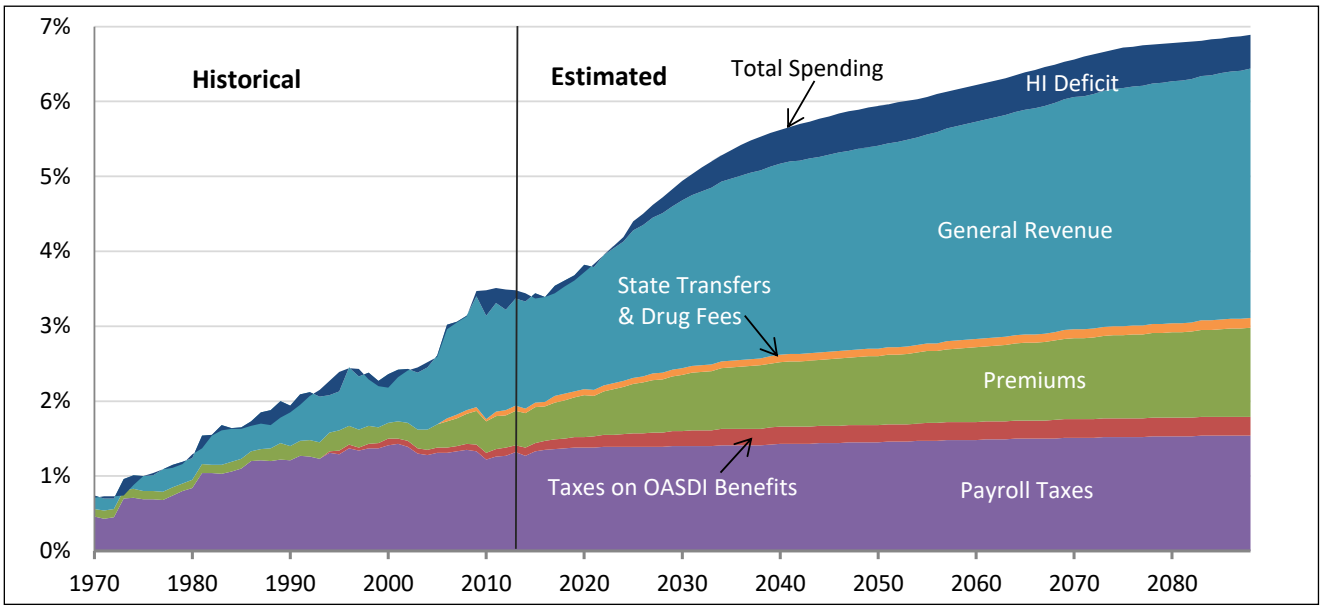
[51] These transfers represent a formal budget requirement under current law.

Medicare Costs as a Percentage of GDP

A comparison of Medicare costs (for Medicare Parts A through D combined) to GDP provides a measure of the amount of financial resources that will be necessary to pay for Medicare services relative to the output of the U.S. economy. The rising costs of health services, increasing utilization rates, and anticipated increases in the complexity of services are expected to contribute to the rising costs of Medicare relative to GDP. Additionally, it is expected that as increasing numbers of people become eligible for Medicare, there will be a significant growth in benefit expenditures. Under current law, the Trustees expect Medicare costs to increase from 3.5% of GDP in 2013 to 5.3% of GDP in 2035 and to 6.9% in 2088. Under the *illustrative alternative*, projected Medicare costs are expected to represent about 8.4% of GDP in 2088. (See **Appendix G** for a comparison of projections of Medicare expenditures as a percentage of GDP from the 2009 through 2014 Trustees reports.)

Over the next 75 years, general revenues and beneficiary premiums are expected to play an increasing role in financing the program. (See **Figure 6**.)

Figure 6. Medicare Cost and Non-Interest Income by Source as a Percentage of GDP



Source: Summary of the 2014 Annual Reports of the Social Security and Medicare Boards of Trustees, http://ssa.gov/oact/TRSUM/index.html, Chart C.

Note: OASDI is Social Security Old-Age and Survivors Insurance.

General revenue transfers to the SMI trust fund are projected to increase from 1.4% of GDP in 2014 to 3.3% in 2088, and beneficiary premiums from 0.5% of GDP in 2014 to 1.2% in 2088. As shown, the share of Medicare income from payroll taxes and taxation of benefits is expected to fall substantially during that period (from 41% to 28%), while the share of general fund revenue is expected to rise (from 43% to 52%), as is the share of premiums (from 14% to 18%). Any excess in projected spending over revenues represents the HI deficit; in 2088, the HI deficit is projected to represent 0.5% of GDP.

Medicare Funding Warning ("Medicare Trigger")[52]

As noted, HI and SMI are financed very differently. HI is funded by current workers through a payroll tax, while SMI is funded by premiums from current beneficiaries and federal general revenues. Because of this financing, the SMI trust fund's income is projected to equal expenditures for all future years. However, there is concern that over time the economy will be unable to support the increasing reliance on general revenues which in large measure comes from taxes paid by the under-65 population. In response, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) required the Trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years (on a fiscal year basis).[53] The law specifies that if an excess general revenue funding determination is made for two successive years, a "Medicare funding warning" is triggered, and the President is to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposals on an expedited basis; however, passage of legislation within a specific time frame is not required. To date, no legislation has been enacted to specifically respond to these funding warnings.

In each report issued from 2006 through 2013, the Medicare Trustees made a determination of excess general revenue funding.[54] However, in their 2014 report, the Trustees project that general revenues will not exceed 45% of total Medicare outlays within the next 7 fiscal years (FY2014-FY2020), and therefore did not issue a funding warning. The Trustees project that from FY2014 through about FY2022, the expected higher tax income and lower outlays due to ACA provisions and other legislation will result in general revenue funding remaining below the 45% threshold. However, the Trustees estimate that beginning in FY2024, the ratio of dedicated funding and outlays will exceed 45%, grow to 55% by 2043, and stay at that level through 2088.

Proponents of the 45% threshold measurement believe that it can serve as an effective early warning system and that it forces fiscal responsibility. Opponents of the measure suggest that it doesn't adequately recognize a shift towards the provision of more services on an outpatient basis or the impact of the Part D program on general revenue increases, and that other measures, such as Medicare spending as a percentage of GDP, Medicare spending as a portion of total federal spending, or the number of workers subject to payroll taxes per Medicare beneficiary, are better ways to measure the health of the Medicare program.

Medicare Expenditures and the Federal Budget

By law, the annual Medicare Trustees reports focus on the financial status of the Medicare HI and SMI trust funds. Trust fund accounting methods are used to determine whether dedicated sources of Medicare revenue, together with any asset balances, are sufficient to allow the payment of expected expenditures on a timely basis. In contrast, when examining Medicare finances under

[52] For additional information, see CRS Report RS22796, *Medicare Trigger*, by Patricia A. Davis, Todd Garvey, and Christopher M. Davis.

[53] Under the Trigger formula, general revenue funding is defined slightly differently. The main difference is that after the assets in the HI trust fund are depleted, HI deficits are included in the general revenue funding measure when determining whether the 45% threshold has been exceeded.

[54] In other words, the Trustees projected eight consecutive times that the threshold would be exceeded within the first seven years of the projection, and therefore issued a funding warning for seven consecutive years.

unified budget accounting methods, the total flow of money into and out of the U.S. Treasury is typically examined regardless of the source of revenue.[55]

The expected shortfall in payroll taxes needed to fully cover future HI expenses and the rapid growth of SMI, which relies primarily on general revenues for financing, have made it increasingly important to look at Medicare expenditures from the perspective of the federal budget as a whole. To illustrate, over the next 75 years, HI revenues are projected to fall short of expenditures by $3.8 trillion in present value terms. This is the additional amount that is expected to be needed in order to pay HI benefits at the level expected under current law over the next 75 years. Note that the federal liability from a budget perspective includes the beginning accumulated assets in the HI trust fund, as they represent federal payment obligations. In other words, from the budget perspective, the total liability includes both the present value of the HI deficit of $3.6 trillion (see **Table 2**) plus the approximately $0.2 trillion in trust fund assets as of January 1, 2014.

Additionally, general revenue transfers in present value terms of $24.7 trillion are expected to be needed to cover SMI expenditures (Parts B and D combined) over the next 75 years. The Medicare Trustees estimate that, assuming personal and corporate income taxes in the future maintain their historical average level relative to the national economy, the portion of income taxes that will be needed to fund the general revenue portion of SMI will grow from 13.8% in 2014 to 30.6% in 2080 (see **Table 4**).[56]

Table 4. SMI General Revenues as a Percentage of Personal and Corporate Federal Income Taxes

Comparison of Estimates of the 2009-2014 Medicare Trustees Reports

Fiscal Year	Percentage of Income Taxes 2009 Report	Percentage of Income Taxes 2010 Report	Percentage of Income Taxes 2011 Report	Percentage of Income Taxes 2012 Report	Percentage of Income Taxes 2013 Report	Percentage of Income Taxes 2014 Report
Historical						
1970	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
1980	2.2	2.2	2.2	2.2	2.2	2.2
1990	5.9	5.9	5.9	5.9	5.9	5.9
2000	5.4	5.4	5.4	5.4	5.4	5.4
2008	10.9	12.0	12.0	12.0	12.0	12.0
2009	n/a	17.7	17.7	17.7	17.7	17.7
2010	12.2	18.6	19.2	19.2	19.2	19.2
2011	n/a	n/a	18.0	17.2	17.2	17.2
2012	n/a	n/a	n/a	14.4	14.5	14.7
2013	n/a	n/a	n/a	n/a	13.4	13.8
Intermediate Estimates						
2014	n/a	n/a	n/a	n/a	n/a	13.8

[55] Spending is normally categorized either as mandatory (not subject to the appropriations process) or discretionary (must be appropriated). Medicare benefit spending is mandatory, while some administrative costs are discretionary.

[56] This amount is in addition to the HI payroll tax.

Fiscal Year	Percentage of Income Taxes 2009 Report	Percentage of Income Taxes 2010 Report	Percentage of Income Taxes 2011 Report	Percentage of Income Taxes 2012 Report	Percentage of Income Taxes 2013 Report	Percentage of Income Taxes 2014 Report
2020	15.8	15.0	17.1	16.3	15.3	15.4
2030	24.0	19.5	19.9	18.6	19.2	21.1
2040	28.9	21.8	22.1	22.6	22.4	24.2
2050	31.9	22.7	23.0	23.0	23.0	25.7
2060	35.1	24.6	24.7	24.0	24.0	27.4
2070	38.1	25.7	25.7	25.0	25.1	29.3
2080	40.5	26.6	26.3	25.7	25.6	30.6

Source: 2009-2014 Medicare Trustees Reports, Table III.C4 (2009-2011) and Table II.F3 (2012-2014).

Note: Includes the Part D prescription drug benefit beginning in 2006; n/a = not available.

ACA and Medicare Spending

As noted earlier, ACA contains numerous provisions that are expected to reduce Medicare spending growth (both HI and SMI) in future years.[57] The ACA did not reduce beneficiaries' Medicare covered benefits or change Medicare's financing structure. Medicare is still funded primarily through mandatory spending, and aside from certain constraints in HI financing, there are still generally no limits on Medicare spending. The ACA mainly changes the way that payments are made to healthcare providers who provide services to Medicare beneficiaries. Because of these changes, Medicare expenditures *are expected to* be less than they would have been under prior law, but spending *is not limited* to those amounts. Actual benefit spending could be greater or less than projections depending on a variety of factors, including beneficiary health care needs and their utilization of services in a given year. As shown in **Figure 2**, Medicare spending is still expected to increase in the future, just not as quickly as projected under prior law. As Medicare is not "pre-funded," these expected "savings" are neither cut from, nor credited to, the Medicare trust funds.[58] The expected reduction in future Medicare spending mainly just means that the federal government and Medicare beneficiaries are expected to spend less on Medicare benefits than they would have under prior law.

Concluding Observations

As shown in this report, a wide array of measures can be used to describe the short- and long-term financial status of the Medicare program. While trust fund solvency issues are important, they only present part of the picture. When viewed from the perspective of the entire federal budget and the economy, Medicare spending obligations, even under the more optimistic scenario presented in the 2014 Medicare Trustees report, are expected to consume an increasing portion of

[57] For a summary of savings estimates of Medicare ACA provisions, see CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available to congressional clients upon request.

[58] Certain ACA revenue changes, i.e., increased Medicare payroll taxes for high-income workers, and fees paid by brand name drug and medical device manufacturers are, however, specifically credited to the Medicare trust funds. For additional detail, see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

federal budgetary resources over time. Budget experts have expressed concern about the long-run implications of Medicare expenditures on federal deficits; for example, in its long-term budget forecast, CBO noted:

> The long-term budget outlook is much less positive, however. The combination of three factors—the aging of the population, growth in per capita spending on health care, and an expansion of federal subsidies for health insurance—is expected to significantly boost the government's spending for Social Security and major health care programs. Barring changes to current law, that additional spending would contribute to larger budget deficits toward the end of the 10-year period that runs from 2015 to 2024, causing federal debt, which is already quite large relative to the size of the economy, to swell even more.[59]

The Medicare Trustees caution that it is difficult to forecast health and economic indicators over an extended period of time. For example, forecasts are based on the assumption that health spending will outpace GDP growth in the future because it has consistently done so in the past. It is possible that in the future, advances in medical technology, changes in consumer preferences, shifts in the health status of the population, or changes in the way health care services are delivered could result in very different financial outcomes from those estimated in the Trustees report.[60] Further, as evidenced by the issuance of an *illustrative alternative* to the 2014 Trustees report, if changes to current health care policies are enacted (most notably these affecting provider productivity adjustments), future Medicare costs could be significantly different from current projections.

There are no simple solutions to address the problems raised by the rapid growth in health care costs, the economic conditions, and the aging of the population. Additionally, as an entitlement program, Medicare must pay for all medically necessary covered benefits for enrollees; except for constraints placed on the program by the HI financing mechanism, there are no limits on overall Medicare spending. As such, policy options to restrain the growth of Medicare spending will continue to attract considerable interest.

Proposals to reduce Medicare spending generally fall into one of two categories: (1) those that would reduce the federal share of Medicare spending (for example, by increasing beneficiary premiums and/or cost-sharing, changing Medicare eligibility criteria such as age, reducing the range of covered benefits, reducing provider payment amounts, establishing defined federal contributions,[61] or setting federal spending limits); and (2) those that would reduce U.S. health care spending regardless of who is paying (e.g., decreasing medical errors, reducing unneeded, duplicative and/or ineffective care, and reducing fraud and abuse). On the revenue side, options to increase program income may include modifying dedicated Medicare payroll taxes or general income taxes, and/or imposing new fees or dedicated taxes.[62] Some of the above changes could be made while still retaining Medicare's current structure, while others could only be made in the context of major program restructuring. Many of the proposals could be combined as part of an overall reform package.

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[59] "The 2014 Long-Term Budget Outlook," Congressional Budget Office, July 2014, p. 7, http://www.cbo.gov/publication/45471.

[60] For example, information learned from pilot programs and demonstrations mandated by recent legislation, such as changing financial incentives of health care providers and improving the care coordination of beneficiaries with chronic conditions, could lead to long-term changes in how health care is delivered and in the cost of that care.

[61] See CRS Report R43479, *Overview of Health Care Changes in the FY2015 House Budget*, by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez for a description of such a model proposed in the House FY2015 budget.

[62] Additionally, broadening the tax base through increased levels of employment and/or wages (e.g., through economic recovery) would also result in increased Medicare payroll tax income.

The challenge to policy makers will be to slow the growth in Medicare spending over the long term, to establish fair levels of contributions from beneficiaries and taxpayers, and to ensure continued beneficiary access to needed health care services. The Medicare Trustees suggest that prompt action is needed to address both the short- and the long-range financial challenges of the Medicare program; the sooner that solutions can be enacted, the more flexible these solutions can be, and the more gradually they may be phased in.

Appendix A. Medicare Enrollment

Table A-1. Medicare Enrollment, 1970-2085

(in thousands)

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
Historical					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2005	42,233	39,752	1,841	5,794	42,606
2006	43,065	40,361	30,560	7,291	43,436
2007	44,010	41,093	31,392	8,667	44,368
2008	45,150	41,975	32,589	10,010	45,500
2009	46,256	42,908	33,644	11,104	46,604
2010	47,365	43,882	34,772	11,692	47,720
2011	48,549	44,917	35,720	12,382	48,896
2012	50,516	46,468	37,402	13,587	50,862
2013	51,913	47,878	39,095	14,841	52,256
Estimated					
2014	53,651	49,350	40,687	16,237	53,992
2015	55,312	50,794	42,200	16,395	55,651
2016	56,987	52,247	43,742	16,883	57,324
2017	58,689	53,723	45,329	17,636	59,025
2018	60,427	55,231	46,618	18,105	60,761
2019	62,206	56,781	47,947	18,882	62,540
2020	64,028	58,383	49,377	19,722	64,362
2021	65,877	60,011	50,792	20,571	66,210
2022	67,770	61,680	52,242	21,396	68,104
2023	69,662	63,358	53,690	22,179	69,996
2025	73,383	66,649	56,545	23,502	73,718
2030	81,422	73,815	62,712	25,991	81,759
2035	86,438	78,215	66,557	27,532	86,771
2040	88,879	80,419	68,426	[a]	89,207
2045	90,344	81,722	69,550	[a]	90,673

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
2050	92,439	83,617	71,160	[a]	92,772
2055	95,189	86,067	73,275	[a]	95,529
2060	98,707	89,270	75,979	[a]	99,054
2065	102,198	92,414	78,659	[a]	102,548
2070	106,062	95,907	81,624	[a]	106,414
2075	110,003	99,508	84,646	[a]	110,353
2080	112,666	101,910	86,679	[a]	113,004
2085	116,414	105,324	89,545	[a]	116,740

Source: 2014 Medicare Trustees Report, Table V.B4.

a. The Trustees report did not provide enrollment projections separately for Part C beyond 2035.

Appendix B. Total Medicare Income and Expenditures (HI and SMI Combined)

Table B-1. Medicare Income and Expenditures, Calendar Years 1970-2023

($ in billions)

	Income						Expenditures		
Year	Payroll Taxes	General Revenue	Premiums	State Transfers	Interest & Other	Total	Benefit Payments	Admin. Expenses	Total
Historical Data									
1970	$4.90	$1.1	$1.1	—	$1.2	$8.20	$7.1	$0.4	$7.50
1975	11.5	2.6	1.9	—	1.5	17.7	15.6	0.8	16.3
1980	23.8	7.5	3.0	—	2.5	37	35.7	1.1	36.8
1985	47.6	18.3	5.6	—	5.1	76.5	70.5	1.7	72.3
1990	72.0	33.0	11.4	—	9.9	126.3	108.7	2.3	111.0
1995	98.4	39.0	20.7	—	17.3	175.3	181.4	2.8	184.2
2000	144.4	65.9	22.0	—	24.9	257.1	217.4	4.4	221.8
2005	171.4	119.1	39.9	—	27.0	357.5	330.3	6.1	336.4
2006	181.3	171.9	49.0	$5.50	29.4	437.0	402.0	6.3	408.3
2007	191.9	178.4	53.7	6.9	31.3	462.1	425.4	6.3	431.7
2008	198.7	184.1	58.1	7.1	32.7	480.8	461.6	6.6	468.2
2009	190.9	209.9	65.2	7.6	34.7	508.3	502.4	6.6	509.0
2010	182.0	204.6	61.8	4.0	33.6	486.1	515.9	7.1	522.9
2011	195.6	222.8	68.5	7.1	36.0	530.0	541.3	7.8	549.1
2012	205.7	213.9	69.7	8.4	39.1	536.9	565.9	8.2	574.2
2013	220.8	236.8	76.4	8.8	33.0	575.8	575.0	8.0	582.9
Intermediate Estimate									
2014	221.6	247.6	80.7	8.3	36.8	595.0	604.1	7.6	611.7
2015	245.2	266.7	87.3	8.5	39.5	647.2	617.2	8.4	625.5
2016	260.3	268.5	87.9	9.1	42.6	668.6	652.2	9.1	661.3
2017	276.6	297.0	99.9	9.8	47.7	730.9	695.0	9.7	704.7
2018	293.8	320.2	109.1	10.6	52.4	786.0	749.6	10.4	760.1
2019	310.0	347.1	119.3	11.5	56.0	844.0	805.8	11.1	816.9
2020	326.3	390.0	131.2	12.5	61.0	920.9	871.1	11.8	882.9
2021	342.7	401.8	134.4	13.5	65.9	958.3	939.0	12.5	951.6
2022	359.3	445.9	150.3	14.7	70.7	1,040.9	1,012.6	13.3	1,026.0
2023	375.8	483.0	163.3	16.0	75.8	1,113.8	1,090.0	14.2	1,104.1

Source: Data from 2014 Medicare Trustees Report, Tables III.B4, III.C4, III.D3 and VB1.

Notes: Totals do not necessarily equal the sums of rounded components.

Appendix C. Medicare Per Capita Expenditures

Table C-1. Average Medicare Benefit Costs Per Beneficiary, Calendar Years 1970-2023

Year	HI	SMI		Total
		Part B	Part D	
Historical Data				
1970	$270	$115	—	$385
1975	472	205	—	677
1980	929	423	—	1,352
1985	1,579	795	—	2,373
1990	1,979	1,355	—	3,334
1995	3,194	1,867	—	5,061
2000	3,348	2,496	—	5,844
2005	4,440	3,839	—	8,278
2006	4,603	4,117	$1,619	10,338
2007	4,762	4,315	1,630	10,707
2008	4,998	4,576	1,662	11,236
2009	5,197	4,796	1,730	11,723
2010	5,211	4,896	1,808	11,915
2011	5,288	5,028	1,859	12,175
2012	5,182	5,179	1,847	12,209
2013	5,145	5,164	1,901	12,210
Intermediate Estimates				
2014	4,999	5,340	1,904	12,243
2015	4,893	5,310	2,014	12,217
2016	4,992	5,443	2,132	12,567
2017	5,128	5,663	2,266	13,056
2018	5,360	5,936	2,403	13,699
2019	5,534	6,234	2,555	14,323
2020	5,753	6,584	2,716	15,053
2021	5,982	6,937	2,870	15,789
2022	6,220	7,310	3,035	16,565
2023	6,454	7,703	3,206	17,364

Source: 2014 Report of Medicare Trustees, Table V.D1.

Notes: These amounts do not include administrative costs. The expenditure figures reflect total Medicare spending and do not net out amounts funded by non-federal sources (beneficiary premiums and state transfers).

Appendix D. Operation of the Hospital Insurance Trust Fund

Table D-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2023

($ in billions)

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data								
1970	$4.9	$1.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	1.4	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	2.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	3.9	51.4	47.6	0.8	48.4	4.8	20.5
1990	72.0	8.4	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	16.7	115.0	116.4	1.2	117.6	-2.6	130.3
2000	144.4	22.9	167.2	128.5	2.6	131.1	36.1	177.5
2001	152.0	22.7	174.6	141.2	2.2	143.4	31.3	208.7
2002	152.7	25.8	178.6	149.9	2.6	152.5	26.1	234.8
2003	149.2	26.5	175.8	152.1	2.5	154.6	21.2	256.0
2004	156.5	27.5	183.9	167.6	3.0	170.6	13.3	269.3
2005	171.4	28.0	199.4	180.0	2.9	182.9	16.4	285.8
2006	181.3	30.2	211.5	189.0	2.9	191.9	19.6	305.4
2007	191.9	31.9	223.7	200.2	2.9	203.1	20.7	326.0
2008	198.7	32.0	230.8	232.3	3.3	235.6	-4.7	321.3
2009	190.9	34.5	225.4	239.3	3.2	242.5	-17.1	304.2
2010	182.0	33.6	215.6	244.5	3.5	247.9	-32.3	271.9
2011	195.6	33.4	228.9	252.9	3.8	256.7	-27.7	244.2
2012	205.7	37.3	243.0	262.9	3.9	266.8	-23.8	220.4
2013	220.8	30.3	251.1	261.9	4.3	266.2	−15.0	205.4
Intermediate Estimate								
2014	221.6	34.3	255.9	265.0	4.5	269.5	−13.6	191.7
2015	245.2	36.8	281.9	265.0	5.0	269.9	12.0	203.8
2016	260.3	39.9	300.3	277.9	5.4	283.2	17.1	220.8
2017	276.6	43.9	320.4	293.4	5.8	299.2	21.2	242.0
2018	293.8	48.2	342.0	315.8	6.2	322.0	20.0	262.0
2019	310.0	52.8	362.9	335.6	6.6	342.3	20.6	282.6

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
2020	326.3	57.6	383.9	359.3	7.1	366.3	17.5	300.1
2021	342.7	62.2	404.9	384.3	7.5	391.9	13.0	313.2
2022	359.3	66.6	425.9	411.1	8.0	419.1	6.8	319.9
2023	375.8	71.3	447.0	438.7	8.5	447.2	−0.2	319.8

Source: 2014 Medicare Trustees Report, Table III.B4.

Notes: Sums may not equal totals due to rounding.

a. Includes income from the taxation of Social Security benefits, Railroad Retirement account transfers, premiums paid by voluntary enrollees, and interest.

Appendix E. Operation of the Supplementary Medical Insurance Trust Fund, Part B Account

Table E-1. Operation of the Part B Account of the SMI Trust Fund, Calendar Years 1970-2023

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Interest & Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
1970	$1.1	$1.1	$0.0	$2.2	$2.0	$0.2	$2.2	−$0.0	$0.2
1975	1.9	2.6	0.1	4.7	4.3	0.5	4.7	−0.1	1.4
1980	3.0	7.5	0.4	10.9	10.6	0.6	11.2	−0.4	4.5
1985	5.6	18.3	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	1.6	60.3	65.0	1.6	66.6	−6.3	13.1
2000	20.6	65.9	3.4	89.9	88.9	1.8	90.7	−0.8	44.0
2005	37.5	118.1	1.4	157.0	149.2	3.2	152.4	4.6	24.0
2006	42.9	132.7	1.8	177.3	165.9	3.1	169.0	8.3	32.3
2007	46.8	139.6	2.2	188.7	176.4	2.5	178.9	9.7	42.1
2008	50.2	146.8	3.6	200.6	180.3	3.0	183.3	17.3	59.4
2009	56.0	162.8	3.1	221.9	202.6	3.1	205.7	16.2	75.5
2010	52.0	153.5	3.3	208.8	209.7	3.2	212.9	−4.1	71.4
2011	57.5	170.2	5.9	233.6	221.7	3.6	225.3	8.3	79.7
2012	58.0	163.8	5.2	227.0	236.5	3.9	240.5	−13.5	66.2
2013	63.1	185.8	6.1	255.0	243.8	3.3	247.1	7.9	74.1
Intermediate Estimates									
2014	65.6	188.4	6.0	260.1	260.1	2.7	262.8	−2.7	71.4
2015	70.3	202.2	6.1	278.6	265.9	3.0	268.9	9.7	81.1
2016	69.0	198.5	6.2	273.8	280.3	3.3	283.6	−9.8	71.3
2017	78.5	221.8	7.5	307.9	299.5	3.5	303.0	4.9	76.2
2018	85.6	238.4	8.1	332.1	322.4	3.7	326.2	5.9	82.1
2019	93.5	257.9	7.3	358.7	348.3	4.0	352.3	6.4	88.5
2020	103.0	292.1	7.8	402.9	378.3	4.2	382.5	20.4	108.9
2021	104.4	295.1	8.4	407.9	409.8	4.5	414.3	−6.4	102.5
2022	117.4	330.4	9.0	456.8	443.9	4.8	448.7	8.1	110.6
2023	127.5	357.8	9.7	494.9	480.1	5.1	485.2	9.8	120.4

Source: 2014 Medicare Trustees Report, Table III.C4.

Notes: Sums may not equal totals due to rounding.

a. The ACA added an additional source of revenue beginning in 2011, fees assessed on manufacturers and importers of brand-name prescription drugs. Income from these fees is allocated to SMI-Part B and is included in the figures in the "Interest & Other" column.

Appendix F. Operation of the Supplementary Medical Insurance Trust Fund, Part D Account

Table F-1. Operation of the Part D Account in the SMI Trust Fund, Calendar Years 2004-2023

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Transfers from States	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
2004	—	$0.4	—	$0.4	$0.4	—	$0.4	—	—
2005	—	1.0	—	1.0	1.1	—	1.1	−0	−0
2006	$3.5	39.2	$5.5	48.2	47.1	$0.3	47.4	$0.8	$0.8
2007	4.1	38.8	6.9	49.7	48.8	0.9	49.7	0.0	0.8
2008	5.0	37.3	7.1	49.4	49.0	0.3	49.3	0.1	0.9
2009	6.3	47.1	7.6	61.0	60.5	0.3	60.8	0.1	1.1
2010	6.5	51.1	4.0	61.7	61.7	0.4	62.1	−0.4	0.7
2011	7.7	52.6	7.1	67.4	66.7	0.4	67.1	0.3	1.0
2012	8.3	50.1	8.4	66.9	66.5	0.4	66.9	0.0	1.0
2013	9.9	51.0	8.8	69.7	69.3	0.4	69.7	0.0	1.0
Intermediate Estimates									
2014	11.6	59.2	8.3	79.1	79.0	0.4	79.4	−0.3	0.7
2015	13.6	64.5	8.5	86.7	86.3	0.4	86.7	0.0	0.7
2016	15.4	70.0	9.1	94.5	94.0	0.4	94.5	0.1	0.8
2017	17.7	75.2	9.8	102.6	102.1	0.4	102.6	0.1	0.8
2018	19.6	81.8	10.6	112.0	111.4	0.5	111.9	0.1	0.9
2019	21.7	89.2	11.5	122.4	121.9	0.5	122.3	0.1	1.0
2020	23.8	97.9	12.5	134.1	133.5	0.5	134.0	0.1	1.1
2021	25.3	106.7	13.5	145.5	144.9	0.5	145.4	0.1	1.1
2022	28.0	115.5	14.7	158.3	157.6	0.5	158.2	0.1	1.2
2023	30.6	125.2	16.0	171.8	171.2	0.6	171.7	0.1	1.4

Source: 2014 Medicare Trustees Report, Table III.D3.

Notes: Sums may not equal totals due to rounding.

Appendix G. Medicare Expenditures as a Percentage of GDP

Table G-1. Projected Hospital Insurance Expenditures as a Percentage of GDP

Comparison of 2009 - 2014 Medicare Trustees Report Estimates

Year	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2014 Report
2009	1.71%	1.67%	1.67%	1.70%	1.69%	1.64%
2010	1.71	1.66	1.69	1.68	1.68	1.62
2020	2.05	1.63	1.70	1.70	1.64	1.53
2030	2.75	1.99	2.03	2.16	2.06	1.91
2040	3.43	2.24	2.27	2.53	2.37	2.17
2050	3.85	2.27	2.30	2.62	2.46	2.26
2060	4.21	2.23	2.26	2.63	2.47	2.28
2070	4.61	2.21	2.24	2.70	2.54	2.35
2080	4.96	2.17	2.16	2.73	2.56	2.37

Sources: 2009 - 2014 Reports of the Medicare Trustees, Table III.A2 (2009-2011), Table V.B2 (2012), and Table V.B3 (2013 & 2014).

Table G-2. Projected Supplementary Medical Insurance—Part B Expenditures as a Percentage of GDP

Comparison of 2009 - 2014 Medicare Trustees Report Estimates

Year	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2014 Report
2009	1.44%	1.45%	1.46%	1.48%	1.47%	1.43%
2010	1.38	1.49	1.46	1.48	1.48	1.44
2020	1.76	1.61	1.63	1.65	1.65	1.62
2030	2.30	2.10	2.15	2.25	2.25	2.24
2040	3.15	2.30	2.34	2.42	2.45	2.53
2050	3.47	2.33	2.36	2.41	2.45	2.66
2060	3.82	2.39	2.40	2.45	2.50	2.82
2070	4.16	2.45	2.44	2.50	2.56	2.99
2080	4.43	2.47	2.43	2.52	2.56	3.09

Source: 2009 - 2014 Reports of the Medicare Trustees, Table III.A2 (2009-2011), Table V.B2 (2012), and Table V.B3 (2013 & 2014).

Table G-3. Projected Supplementary Medical Insurance—Part D Expenditures as a Percentage of GDP

Comparison of 2009 - 2014 Medicare Trustees Report Estimates

Year	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2014 Report
2009	0.43%	0.41%	0.41%	0.42%	0.42%	0.40%
2010	0.45	0.43	0.43	0.43	0.43	0.42
2020	0.71	0.67	0.67	0.61	0.58	0.57
2030	1.08	1.02	0.98	0.88	0.83	0.79
2040	1.28	1.21	1.15	1.02	0.97	0.92
2050	1.42	1.35	1.28	1.11	1.07	1.02
2060	1.57	1.50	1.42	1.23	1.18	1.12
2070	1.69	1.63	1.55	1.35	1.29	1.23
2080	1.80	1.75	1.66	1.45	1.38	1.32

Source: 2009 - 2014 Reports of the Medicare Trustees, Table III.A2 (2009-2011), Table V.B2 (2012), and Table V.B3 (2013 & 2014).

Table G-4. Projected Total Medicare Expenditures as a Percentage of GDP

Comparison of 2009 - 2014 Medicare Trustees Report Estimates

Year	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2014 Report
2009	3.59%	3.53%	3.54%	3.59%	3.58%	3.47%
2010	3.54	3.59	3.58	3.59	3.59	3.48
2020	4.53	3.91	3.99	3.96	3.88	3.72
2030	6.43	5.11	5.16	5.29	5.14	4.94
2040	7.96	5.76	5.77	5.97	5.79	5.62
2050	8.74	5.94	5.94	6.15	5.98	5.94
2060	9.60	6.12	6.09	6.31	6.15	6.22
2070	10.46	6.29	6.22	6.55	6.40	6.56
2080	11.18	6.37	6.25	6.69	6.50	6.78

Source: 2009 - 2014 Reports of the Medicare Trustees, Table III.A2 (2009-2011), Table V.B2 (2012), and Table V.B3 (2013 & 2014).

Author Information

Patricia A. Davis
Specialist in Health Care Financing

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